SERFF Tracking Number:	*MTLC-126430356*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	*44461*
Company Tracking Number:	*6330-09*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Part II of Life Application*		
Project Name/Number:	*Part II of Life Application/6330-09*		

Filing at a Glance

Company: MTL Insurance Company

Product Name: Part II of Life Application	SERFF Tr Num: MTLC-126430356	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 44461
Sub-TOI: L08.000 Life - Other	Co Tr Num: 6330-09	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Laura Callahan	Disposition Date: 01/04/2010
	Date Submitted: 12/23/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Part II of Life Application	Status of Filing in Domicile: Pending
Project Number: 6330-09	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type:	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 01/04/2010	Explanation for Other Group Market Type:
	State Status Changed: 01/05/2010
Deemer Date:	Created By: Laura Callahan
Submitted By: Laura Callahan	Corresponding Filing Tracking Number:

Filing Description:

Form 6330-09 is the Part II of our life application. This is a new form that is being filed for approval and does not replace any existing forms that were previously approved.

This form will be used with our life application Form 6300-08 which was previously approved in your state.

Company and Contact

Filing Contact Information

Laura Callahan, Product Filing Coordinator	CallahanL@mutualtrust.com

SERFF Tracking Number:	*MTLC-126430356*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	*44461*
Company Tracking Number:	*6330-09*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Part II of Life Application*		
Project Name/Number:	*Part II of Life Application/6330-09*		

1200 Jorie Blvd.
Oak Brook, IL 60522

630-684-5319 [Phone]
630-684-5487 [FAX]

Filing Company Information

MTL Insurance Company	CoCode: 66427	State of Domicile: Illinois
1200 Jorie Blvd.	Group Code:	Company Type: Life
Oak Brook, IL 60522	Group Name:	State ID Number:
(800) 323-7320 ext. [Phone]	FEIN Number: 36-1516780	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	1 form @ 50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
MTL Insurance Company	$50.00	12/23/2009	33059948

SERFF Tracking Number:	*MTLC-126430356*	*State:*	*Arkansas*
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Product Name:	*Part II of Life Application*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/04/2010	01/04/2010

SERFF Tracking Number:	*MTLC-126430356*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	*44461*
Company Tracking Number:	*6330-09*		
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Product Name:	*Part II of Life Application*		
Project Name/Number:	*Part II of Life Application/6330-09*		

Disposition

Disposition Date: 01/04/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MTLC-126430356*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	*44461*
Company Tracking Number:	*6330-09*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Part II of Life Application*		
Project Name/Number:	*Part II of Life Application/6330-09*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form	Part II of Life Insurance Application		Yes

SERFF Tracking Number:	*MTLC-126430356*	*State:*	*Arkansas*
Filing Company:	*MTL Insurance Company*	*State Tracking Number:*	*44461*
Company Tracking Number:	*6330-09*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Part II of Life Application*		
Project Name/Number:	*Part II of Life Application/6330-09*		

Form Schedule

Lead Form Number: 6330-09

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form No. 6330-09	Application/ Enrollment Form	Part II of Life Insurance Application	Initial		51.430	Form No. 6330-09.pdf

MTL INSURANCE COMPANY

1200 Jorie Boulevard • Oak Brook, Illinois 60523-2269

PART II
of application to
Answers made to Medical Examiner

1. PRINT Full Name and Date of Birth

_____ _____ _____ Born: _____

First Middle Last Month Day Year

		Yes	No
2.	**Have you, in the past 10 years been advised of, diagnosed, tested positive for, sought consultation for, or been treated for:**		
a.	Convulsions, seizures, paralysis, stroke, mental or nervous disorder, attempted suicide, or recurrent dizziness, fainting or headaches?		
b.	Asthma, emphysema, tuberculosis, bronchitis or chronic respiratory disorder, sleep apnea or persistent shortness of breath?		
c.	Chest pain or tightness, palpitations, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels?		
d.	Hepatitis, intestinal bleeding, ulcer, colitis, recurrent diarrhea or indigestion, or other disorder of the stomach, intestines, liver or pancreas?		
e.	Sugar, albumin, blood or pus in urine, venereal disease, or other disorder of the kidney, bladder, prostate, breasts or reproductive organs?		
f.	Diabetes, thyroid or other endocrine disorders?		
g.	Arthritis or disorder of the muscles or bones, spine, back or joints?		
h.	Disorder of skin, lymph glands, cyst, tumor or cancer?		
i.	Disorder of the eyes, anemia or other disorder of the blood?		
3.	**Have you, within the past 10 years, been medically diagnosed or treated by a physician as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other immunological disorder?**		
4.	**Have you in the past 10 years:**		
a.	Used barbiturates, heroin, cocaine, marijuana, or any other illegal or controlled substance, except as prescribed by a physician?		
b.	Been advised to seek, or received counseling or treatment, or attended or joined any organization for alcohol or drug dependence?		
5.	**Other than above, have you in the past 5 years:**		
a.	Been diagnosed or treated for a mental or physical disorder, illness, injury or surgery?		
b.	Had a checkup or other consultation?		
c.	Been a patient in a hospital, clinic, medical center or other medical facility?		
d.	Had an EKG, stress test or any other diagnostic test?		
e.	Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?		
f.	Requested or received a pension, benefits, or payment because of an injury, sickness or disability?		
6a.	Have you lost or gained more than 15 lbs. in the past year? If "yes," indicate reason and amount of gain or loss.		

		Yes	No
b.	Used tobacco or nicotine in any form in the past 12 months?		
c.	Used tobacco or nicotine in any form in the past 48 months?		
7.	Are you now under observation by a physician or taking any prescription medication(s)?		
8.	Has any family member been diagnosed with diabetes, cancer, stroke, heart or kidney disease, or mental illness?		

	Age if Living	Cause of Death	Age at Death
Father			
Mother			
Brothers & Sisters			
No. Living			
No. Dead			

9. DETAILS of "Yes" answers. (IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS. Include diagnoses, prescription medication(s), dates, duration, and names and addresses of all attending physicians and medical facilities.)

If more space is needed, attach on separate page.

I have read the statements and answers recorded above which have been made by me in continuation of and as part of the application for insurance. I hereby represent that such statements and answers, to the best of my knowledge and belief, are complete and true. I agree that they shall be a basis for any contract of insurance that may be issued.

Any person who knowingly presents a false statement in an application for insurance may be guilty of criminal offense and subject to penalties under state law.

Dated at _____ Date signed _____

Witness _____ _____ Insured

Medical Examiner

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the MTL Insurance Company any such information. This authorization shall permit the above named company, its reinsurer(s) or its representative, and any consumer reporting agency to view, copy, be furnished copies, or be given details of: (a) medical and other history; (b) mental or physical conditions; (c) evaluation, diagnosis, treatment, and prognosis of mental or physical conditions. Such information shall specifically include psychiatric treatment and drug or alcohol abuse treatment. A photocopy of this authorization shall be as valid as the original. This authorization expires two years after the date of the policy. I acknowledge receipt of the disclosure statements regarding the investigative consumer report and the Medical Information Bureau, and authorize the company to obtain a consumer investigative report if deemed necessary.

Date _____

Witness _____ _____ Insured

Mail this form to: MTL Insurance Co., Underwriting Department, 1200 Jorie Blvd., Oak Brook, IL 60523-2269

DO NOT DETACH **VOUCHER FOR MEDICAL EXAMINATION** DO NOT DETACH

Please Print

Name of person examined _____ _____
Fee

Date examined _____ Name of Agent _____

Name of examiner _____ Soc. Sec. No. _____

Address of examiner _____ _____
STREET AND NUMBER OFFICE PHONE NUMBER

_____
CITY AND STATE ZIP

MEDICAL EXAMINER'S REPORT
(Both sides of this form are to be completed by the Medical Examiner)

1. a. Height (in shoes) ft. in.	Scale Weight (clothed) lbs.	**Males Only:** Chest (full inspiration) in.	Chest (forced expiration) in.	Abdomen, at Umbilicus in.

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

c. Is appearance unhealthy or older than stated? ☐ Yes ☐ No

2. Blood Pressure: (If systolic reading over 140 or diastolic over 90, or if Insured is markedly overweight, obtain three readings at intervals.)

	Initial	Additional Readings
Systolic		
Diastolic (5th Phase)		

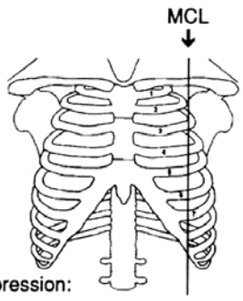
3. Pulse:

	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per minute			

4. Heart: Is there any:
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(Describe below - if more than one, describe separately.)

Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

Indicate:
Apex by ×
Murmur area by ☐
Point of greatest intensity by ○
Transmission by →



For comment and your impression:

5. Is there on examination any abnormality of the following:
(Circle applicable items and give details.)

		Yes	No
a.	Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
b.	Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
c.	Nervous system (include reflexes, gait, paralysis, tremors)?	☐	☐
d.	Respiratory system?	☐	☐
e.	Abdomen (include scars)?	☐	☐
f.	Genitourinary system (include prostate)?	☐	☐
g.	Endocrine system (include thyroid and breasts)?	☐	☐
h.	Musculoskeletal system (include spine, joints, amputation, deformities)?	☐	☐

9. Details of "Yes" answers. (Identify item.)

6. Are there any hernias? ☐ Yes ☐ No

7. Are you aware of additional medical history? ☐ Yes ☐ No (A confidential report may be sent to the Medical Director.)

8. Have you known Insured previously? ☐ Yes ☐ No

Urinalysis: Specific Gravity	Albumin	Sugar

Is specimen being sent to Company lab? ☐ Yes ☐ No

Send urine specimen if Insured is applying for $100,000 or more of life insurance, or is (a) hypertensive or has other cardiovascular abnormalities, (b) markedly overweight, or (c) age 60 and over.
Send 2 specimens (different days) if albumin, sugar, pus, blood or casts are present, or were found in past.

I have examined the Proposed Insured in private at: ☐ My Office ☐ Proposed Insured's Residence
☐ Proposed Insured's Place of Business ☐ _____

At _____ A.M./P.M. _____ Date _____ M.D.
Medical Examiner

Form No. 6330-09

SERFF Tracking Number:	*MTLC-126430356*	*State:*	*Arkansas*
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Project Name/Number:	*Part II of Life Application/6330-09*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

STATE OF ARKANSAS compliance form.pdf

Readability.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

Life app, Form 6300-08 AR will be used with this part II of the app and was approved in your DOI on December 17, 2008.

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: MTL Insurance Company

Form Title(s): Part II of Life Insurance Application

Form Numbers(s): 6330-09

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19 and 49, as well as the other laws and regulations of the State of Arkansas.

Roger L. Barth, FSA, MAAA
Vice President

December 23, 2009
Date

CERTIFICATION OF READABILITY

State of
Arkansas

Form Number	Flesch Readability Score
6330-09	51.43

I certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the readability, legibility, and format requirements of any applicable laws and regulations in the state of Arkansas.

MTL Insurance Company
Company

Roger Barth
Digitally signed by Roger Barth
DN: cn=Roger Barth, o=MTL Insurance Co., ou=Product Development, c=US
Date: 2009.12.23 13:39:23 -06'00'
Signature

Roger L Barth, FSA, MAAA
Name

Vice President, Product Development
Title

12/23/2009
Date